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AHIP AHM-510

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QUESTION NO: 1

There are several exceptions to the Ethics in Patient Referrals Act and its amendments (the Stark laws), which prohibit a physician from referring Medicare or Medicaid patients for certain designated services or supplies provided by entities in which the physician has a financial interest. Consider whether the situations described below qualify as exceptions to the Stark laws:

Situation A: Dr. Wong is a physician in the Marvel Health Plan's provider network and has a financial relationship with Marvel arising from the health plan's compensation for his services. Marvel is not a prepaid health plan.

Situation B: Dr. Ryder is a physician in the provider network of the Glen Health Plan, which is not a prepaid health plan. In situations of medical necessity, Dr. Ryder refers Glen patients to a physical therapy clinic that leases office space from him.

Situation C: Dr. Yost has a compensation arrangement with a health plan for providing health services under the Medicare+Choice program.

An arrangement that is exempt from the Stark laws is described in

- A. All of these situations
- B. Situations A and C only
- C. Situation B only
- D. Situation C only

ANSWER: D**QUESTION NO: 2**

The following statements are about the Federal Employees Health Benefits Program (FEHBP), which is administered by the Office of Personnel Management (OPM). Three of the statements are true and one statement is false. Select the answer choice that contains the FALSE statement.

- A. For every plan in the FEHBP, OPM annually determines the lowest premium that is actuarially sound and then negotiates with each plan to establish that premium rate.
- B. Once a health plan has submitted its rate proposals for a contract year to the OPM, it cannot adjust its premium rate for any reason.
- C. To cover its administrative costs, OPM sets aside 1% of all FEHBP premiums.
- D. Each spring, OPM sends all plan providers its call letter, a document that specifies the kinds of benefits that must be available to plan participants and cost goals and procedural changes that the plans need to adopt.

ANSWER: A**QUESTION NO: 3**

The Tidewater Life and Health Insurance Company is owned by its policy owners, who are entitled to certain rights as owners of the company, and it issues both participating and nonparticipating insurance policies. Tidewater is considering converting to the type of company that is owned by individuals who purchase shares of the company's stock. Tidewater is incorporated under the laws of Illinois, but it conducts business in the Canadian provinces of Ontario and Manitoba.

With regard to the state in which Tidewater is domiciled, it is correct to say that, from the perspective of both Ontario and Manitoba, Tidewater is considered to be the type of corporation known as:

- A. A foreign corporation
- B. An alien corporation
- C. A sister corporation
- D. A domestic corporation

ANSWER: B

QUESTION NO: 4

Indigo Health Plan advertised a specific individual health insurance policy through a direct mail advertisement that provided detailed information about the product. In order to comply with the NAIC Model Rules Governing Advertisements of Accident and Sickness Insurance, Indigo must disclose whether the advertised policy contains any exceptions, reductions, or limitations. Thus, Indigo disclosed in the advertisement that one policy provision limits coverage for dental exams to \$50 per exam and to one exam per calendar year. This information indicates that, with respect to the definitions in the NAIC Model Rules, Indigo's advertisement is an example of an

- A. Invitation to contract, and it discloses a policy provision known as an exception
- B. Invitation to contract, and it discloses a policy provision known as a reduction
- C. Invitation to inquire, and it discloses a policy provision known as an exception
- D. Invitation to inquire, and it discloses a policy provision known as a reduction

ANSWER: B

QUESTION NO: 5

Certificate of need (CON) laws apply to health plans in a variety of ways, depending upon the state. By definition, CON laws are laws that are designed to

- A. Regulate the construction, renovation, and acquisition of healthcare facilities as well as the purchase of major medical equipment in a geographical area
- B. Protect commerce from unlawful restraint of trade, price discrimination, price fixing, reduced competition, and monopolies
- C. Determine benefit payments when a person is covered by more than one plan, such as two group health plans
- D. License and regulate health plans that wish to establish and operate an HMO

ANSWER: A**QUESTION NO: 6**

There are several approaches to the interagency division of responsibility for managed care entity (MCE) oversight. In State M, the state Medicaid agency, the state department of health, and the state insurance department are all responsible for ensuring that quality improvement programs are in place among the same group of MCEs and that these programs meet each agency's rules and regulations for such programs. This information indicates that State M uses the approach known as the

- A. Parallel model
- B. Shared model
- C. Concurrent model
- D. PACE model

ANSWER: C**QUESTION NO: 7**

The Westchester Health Plan is using a pricing strategy that involves setting a low price in a highly price-sensitive market to stimulate revenue growth. In following this strategy, Westchester is sacrificing short-term profits for fast growth in selected markets. This information indicates that Westchester is following the pricing strategy known as

- A. Market skimming
- B. Buying market share
- C. Price skimming
- D. Unitary pricing

ANSWER: B**QUESTION NO: 8**

Third party administrators (TPAs) provide various administrative services to health plans or groups that provide health benefit plans to their employees or members. Many state laws that regulate TPAs are based on the NAIC Third Party Administrator Model Statute. One provision of the TPA Model Law is that it

- A. Prohibits TPAs from performing insurance functions such as underwriting and claims processing
- B. Prohibits TPAs from entering into an agreement under which the amount of the TPA's compensation is based on the amount of premium or charges the TPA collects
- C. Requires TPAs, upon the termination of a TPA agreement with a group, to immediately transfer all its records relating to the group to the new administrator

D. Requires TPAs to notify the state insurance department immediately following any material change in the TPA's ownership or control

ANSWER: D

QUESTION NO: 9

Antitrust laws can affect the formation, merger activities, or acquisition initiatives of a health plan. In the United States, the two federal agencies that have the primary responsibility for enforcing antitrust laws are the

- A. Internal Revenue Service (IRS) and the Department of Justice (DOJ)
- B. Office of Inspector General (OIG) and the Department of Defense (DOD)
- C. Federal Trade Commission (FTC) and the Department of Labor (DOL)
- D. Federal Trade Commission (FTC) and the Department of Justice (DOJ)

ANSWER: D

QUESTION NO: 10

The Hanford Health Plan has delegated the credentialing of its providers to the Sienna Group, a credential verification organization (CVO). If the contract between Hanford and Sienna complies with all of the National Committee for Quality Assurance (NCQA) guidelines for delegation of credentialing, then this contract

- A. Transfers to Sienna all rights to terminate or suspend individual practitioners or providers in Hanford's provider network

Both A and B

- B. Describes the process by which Hanford evaluates Sienna's performance in credentialing providers

A only

C. B only

D. Neither A nor B

ANSWER: C